MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Wednesday, January 16, 2002
9:34 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
BEATRICE S. BRAUN, M.D.
SHEILA P. BURKE
AUTRY O.V. "PETE" DeBUSK
ALLEN FEEZOR
FLOYD D. LOOP, M.D.
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
JANET G. NEWPORT
CAROL RAPHAEL
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

AGENDA item:
Assessing payment adequacy and updating Medicare payments to hospitals: payment adequacy, base rate differential, inpatient update, outpatient update
Jesse Kerns, Craig Lisk, Jack Ashby, Chantal Worzala

MR. KERNS: I'm going to open our presentation with a review of the hospital financial performance under Medicare that you saw last month.

First, the overall Medicare margin in 2002, our best estimate, which includes payment policy changes that were slated for 2003, creates a margin of 3.8 percent. The only thing that has changed since December is the rural margin went up a couple of tenths of a point since I was able to remove a few more critical access hospitals from our 2002 estimate. This did not have enough of an effect to change the overall all hospital estimate.

Next is just a brief review of the inpatient margin because we're here today to discuss and decide on the inpatient payment update. Again, our estimate of the inpatient margin in 2002 remains at 10.8 percent, as in December. This does include the reduction in IME payments slated for 2003.

The next slide, similar to the slides you saw this morning in Craig's presentation, shows the distribution of the inpatient margin values by hospitals by hospital location. Along the bottom of the graph we show hospital margins in 5 percentage point increments and the side bar has the percent of hospitals in each margin category.

This first graph shows the margin that includes all DSH and IME payments. These payments create the bulge on the right side of the distribution for large urban hospitals.

We note that the distribution for each of the three groups is fairly wide and that there is substantial overlap among the three groups. In other words, the differences among hospital margins within a group are far more pronounced than margin differences between groups.

When we consider the idea of margins by group, as in the tables we presented at the beginning of this presentation, large hospitals with high margins dominate because these margins are revenue weighted.

In the next slide we recreated the inpatient margin distribution after removing DSH payments and IME payments above Medicare's share of teaching costs. As you can see, without these payments the distribution for these three groups is much more uniform. We also note the distribution is still quite wide and the differences between hospitals within the group are much more pronounced than differences between groups.

One other interesting point, the group with the largest proportion of hospitals with relatively high margins, say above 20 percent, is rural hospitals.

DR. ROWE: Say that again.

MR. KERNS: If you see on the right side of the

distribution, there is a portion of the rural hospitals, a decent number, that have margins 20 percent or higher. When you take out the DSH and the IME --

DR. ROWE: Medicare margins.

MR. KERNS: Yes, Medicare inpatient margins.

DR. REISCHAUER: These are hospitals where we're counting a hospital with 10 beds and a hospital with 500 the same.

MR. KERNS: Exactly. This is hospital-weighted, which is why the distribution looks a lot different than the aggregate, revenue-weighted margins you saw on the first two slides.

DR. NEWHOUSE: So these are critical access hospitals?

MR. KERNS: Critical access hospitals have been excluded to the best of my ability from this distribution because I'm taking 1999 margins and projecting -- these are 1999 margins and I've taken out those that I can.

DR. ROWE: Do you have the total margins, rather than just -- I would expect the rural hospitals' margins would be much higher than 20 percent.

MR. KERNS: It's interesting you should bring that up. Not in the presentation, but in the overhead slides I prepared, I did do one for total margin by large urban, other urban and rural. Susanne has had that in her back pocket. There you go. Fairly uniform, not what you'd expect to see.

DR. ROWE: Interesting. So what happens is that bulge in the rural gets flattened out when you look at the total margins.

MR. KERNS: Yes.

DR. ROWE: Good. Thank you.

DR. WAKEFIELD: Is this total Medicare margins?

MR. KERNS: No. To be clear, this here is total margin, all payers, all sources of revenue. We could done this for overall Medicare margins instead of inpatient, but we're talking about the inpatient update.

DR. WAKEFIELD: Just want to be really clear about inpatient, outpatient total, including Medicare and all other payers, versus all Medicare.

MR. KERNS: Yes, that's why I made it overall Medicare margin, rather than total Medicare margin, so there would be confusion.

Even we don't have the slides for this, I did prepare the same graphs for overall Medicare margin instead of inpatient, and they're basically the same as the inpatient. You see the same bulge and you see that when you remove the DSH and the IME, it becomes very uniform.

DR. ROWE: This morning, Sheila suggested removing DSH but not IME, and I think others supported that. You don't happen to know what looks like, do you?

MR. KERNS: I was thinking about this when you were asking about it this morning. To the best of my knowledge, it's going to be about one-third of the impact when you just remove the IME and two-thirds when you just remove the DSH, when it's the portion above. Of course, it's going to move the same hospitals in the same direction because most hospitals that receive DSH also receive IME, and vice versa.

DR. ROWE: Right, so what you're saying, just to clarify, is

if we remove the DSH because that's something else, that that would be two-thirds of the effect of IME and DSH together?

MR. KERNS: This is the rough estimate off the top of my head. But the same thing would happen. You'd see that the bulge would move in and it would look a lot like this one here, that Susanne has just put up. When you exclude just the DSH, you'll probably see more of a rightward bulge in the red line and in the blue line, but the green line isn't going to move too much. They don't receive IME.

MR. MULLER: Just to make sure I follow the proportions, by two-thirds, you say DSH is roughly two-thirds of the effect.

MR. KERNS: Believe, there's somebody behind me, I'm sure, saying that I'm a little wrong. But if you think that DSH and IME are probably -- if the IME payments, if half of that is a subsidy, and let's just say that they're about the same size to begin with, and you take away half of the IME and you've got two-thirds being DSH and one-third being IME. In terms of actual dollars, I'm sure I'm a little off.

The next step, of course, is to talk about payment adequacy. As you may recall from the last meeting, and from the mailing materials, we reviewed a number of factors in our assessment of payment adequacy. We found no evidence that the cost base was inappropriate. In the 1990s, hospital cost growth was unusually low due to length of stay decline. And from 1999 through 2001, cost growth increased as length of stay decline slowed and hospital wages increased. We determined the cost growth resulting from these trends was justifiable.

So our best estimate of the overall Medicare margin in 2002, after accounting for 2002 payment policy, is 3.8 percent. This appears to be consistent with the conclusion that payments are adequate. This conclusion is fundamental to the discussion that will follow.

MR. DEBUSK: Now define adequate for me.

MR. KERNS: Does it seem too low, does it seem too high, or does it seem within a band of payment adequacy? Does it seem that 3.8 percent is just to low?

MR. DEBUSK: So we're setting income for the hospitals?

MR. KERNS: I'm sorry? Of course, we've had the same debate last month, how hard it would be to set a target. But if you think of a band of adequacy, is it plausible that 3.8 percent falls completely below the band of adequacy?

MR. HACKBARTH: I think the silence is assent in this case. At least that's the way I interpret it. Correct me if I'm wrong.

DR. ROWE: I'd just like to comment with respect to comments I made earlier regarding broadening our consideration of the financial component, notwithstanding the social good component, into things beyond just margins and looking at financial stability of institutions, balance sheet considerations, capital considerations, et cetera, credit worthiness, that a 3.8 percent overall margin seems to be consistent -- from the data that I've seen at least -- with an investment grade bond rate. So it seems to be consistent with access to the capital market, which is one of the considerations that I think we should take into account.

DR. WAKEFIELD: Are we commenting on what has been presented so far?

MR. HACKBARTH: I think the reason Jesse paused is he came to a critical conclusion that sort of lays the foundation for subsequent discussion, namely that the 3.8 percent overall Medicare margin represents something within the range of adequacy. And he's, I think, looking for any reaction to that. So if you have a comment on that particular point, now is the time.

DR. LOOP: I think the 3.8 may be adequate if the figure 3.8 is accurate. I mean, I'm not positive that 3.8 overall Medicare margin is fact. If it is, then okay, that's adequate.

MR. HACKBARTH: As you well know, Floyd, we are plagued with some data issues here. We are working from a relatively old database, older than we usually need to work with. As Murray pointed out earlier today, though, in updating the cost estimates to the year 2002, we think we've used -- the staff thinks it's used relatively generous estimates of the rate of increase in costs. Basically, it's used the market basket, as I understand it, to increase costs.

Jesse, I'm in over my head.

MR. KERNS: In your mailing materials, the trends that are used for each of these are -- it's not just the market basket. There are a few other indicators we used and there are other adjustments we made. You'd have to review the mailing materials, I can't do it right here off the top of my head.

MR. HACKBARTH: It seems to me like it's an important point. Jack, can somebody just -- if it isn't a market basket increase from '99, can somebody briefly describe what it was?

MR. KERNS: We did use cost per adjusted admission as an indicator and we did also -- several things were factored in. If I had the chapter in front of me I could flip to the footnote. Maybe somebody has that. Good.

So there we are. AHA cost per adjusted admission for 2001 and 2002, and in 2002 a small adjustment for length of stay decline.

DR. ROSS: Let me speak to Floyd's larger point here, though, which is obviously there's some uncertainty about this any way when you try to bring forward three-year-old data and say what might have happened. We know the payment rules with a fair amount of precision. We have some evidence of what we can assume about input price growth. We've got actual market basket, since we're actually backcasting here.

What you don't know is behavioral change. We don't know, for example, on the outpatient side, what kind of coding response there's been to the introduction of prospective payment system. There's a host of those issues.

Your larger point is well taken, that this is our estimate. Several months ago we introduced a band of uncertainty around that and that's where we turn the ball over to you guys and ask whether you're able to live with those things. But you won't get more precision.

MR. KERNS: I want to correct myself. It actually was the market basket in '01 and '02. We used cost per adjusted

admission just for 2000.

MR. HACKBARTH: But there was a conscious effort, as I understand it, to try to err on the side of being generous? For example, in '01 and '02, where it was just the market basket, that implies that there was no change for declining length of stay?

MR. KERNS: There was a small estimate.

MR. HACKBARTH: For '01 and '02?

MR. KERNS: Yes. In an earlier study that Jack Ashby did, he found a correlation between declines in length of stay and change in cost per case of about 0.8 to one. So for each 1 percent decline in length of stay, cost per case would go down by about 0.8 percent.

We adjusted that downward because we thought that might be generous. That study came from a period of time in the mid-'90s when length of stay was going down a lot. I believe we brought it down to about 0.5 to one.

We knew there was a correlation but we didn't want to overestimate it or overstate it, so we reduced it a little. It's a sort of methodological issue. I can write something up on that so it's easier for the commissioners.

DR. ROSS: That's just on the inpatient side. On the outpatient, we did market basket is my recollection.

MR. KERNS: Yes.

DR. ROSS: Even though we'd expect coding improvement in response to the PPS.

DR. WAKEFIELD: Jesse, this is just a comment on the information that we're looking at in the charts on overall Medicare margin and inpatient Medicare margin. I've raised this before but I'm raising it again.

If ever, and whenever, we can have breakdowns so that we're not lumping all of rural into one category in terms of being able to show distribution, I at least personally find that fairly helpful.

When we're averaging all of rural, large rurals doing fairly well can obscure some of the smaller rural hospitals that are most vulnerable and about which we might be most concerned and not concerned at all about other different categories of rural.

So in the urban, if you just take the urban breakdown, we've got large urban and we've got other urban. We've got a little more teasing out there.

MR. KERNS: So you know, that's not the size of the hospital. That's the metropolitan area in which that hospital is. So you could have a 25-bed large urban hospital.

DR. WAKEFIELD: So you could do it by urban influence codes, for example.

MR. KERNS: You could do it by UICs, indeed.

MR. HACKBARTH: Just so you know, Mary, just to be clear, the large urban versus other urban is a statutory based distinction. It influences the base rates. This is not an analytical breakdown, it is in the statute.

DR. WAKEFIELD: Thanks for that clarification. I'll still come back to my same point, that I think within this broad span of rural, what we define as rural, we've got different categories

of hospitals that are doing better and worse. I went back and pulled our June report, for example, just to look at what our overall Medicare margins, the differences were for example between rural referral centers and other rurals one to 100 beds. Not insignificant differences. All of that tends to wash out.

So I take your point, Glenn, about statutory. But I'm also making the point that I don't think we're concerned about all urban. We're not concerned about the well-being of all rural. But you can wash out those differences when we aggregate, and that is of concern to me.

You especially see that when you look at outpatients margins, for example, between rural referral centers, again using the widest variation. And small rural Medicare dependents. You made a comment that about -- I can't remember, Jesse -- about 20 percent of rurals -- or that the largest proportion of hospitals that have a plus 20 percent margin are rural hospitals. That's an important point and it begs the question which ones? Is there anything we know about who those are or which ones those are?

MR. KERNS: I can guess.

DR. WAKEFIELD: Or you can guess.

My point here is that periodically in the past we've teased out Medicare margins along these categories of inpatient, outpatient and Medicare overall. And every time we do that I think it's really helpful because it helps focus in on those types of hospitals that are experiencing the greatest problem and those that are coming along just fine, thank you very much. So it's a general point about display of data and helping inform at least my thinking.

MR. KERNS: In the March report we'll do another financial indicators data book in the appendix, so you'll be able to see all the different rural groups that you like.

I would also point out that you're talking about the plight of very small rural hospitals. I brought this up at the last meeting. When we studied these during the June report, there were between 200 and 300, I think it was like 270 critical access hospitals. There's now over 510. There's 2,200 rural hospitals total. At this point, nearly one in four are critical access. They are paid at their costs for inpatient and outpatient, so they're not going to have negative margins, nor will they have positive margins.

DR. WAKEFIELD: And there is that whole other category of possible that still remain and don't have special protection payment policy like Medicare dependent hospital payment policy or --

MR. KERNS: Yes, but at this point there are more rural hospitals eligible for special payments than are not.

DR. WAKEFIELD: So I'm still saying, if I don't know what else is going on with those other hospitals -- first of all, I want to know what's going on with those hospitals, the MDHs, the CAHs, et cetera. But in addition, what's happening to those hospitals that currently don't benefit from any particular payment policy, just like what's happening with large urban versus other urban. And the more we can break that data down the more precise we can be about trying to address any particular

problems that might compromise access to beneficiary care, rather than all rural.

MR. KERNS: I would say that the special payment programs are at least intended to isolate hospitals that are important for access, such as the critical access hospital.

DR. WAKEFIELD: True enough, they are, and we also know that the rest of the hospitals have just been put through major changes shifted over to prospective payment. And so with all of those changes, it begs the question what's happening in terms of the financial well-being of those hospitals?

They've been put through, over the last few years, major revamping of the payment systems that they have to adhere to. Does it matter? Are they doing just as well? Or even better than they did before? All of that. See, I feel kind of strongly about this.

DR. REISCHAUER: But, Mary, what if they weren't doing well? If we have a program that says the ones that are critically important for access we'll take care of, and we change overall payment policy and the other ones take it on the chin? I mean, is the function of Medicare to keep every institution alive?

DR. WAKEFIELD: Not at all. But part of what we've just done is change a lot of the payment policy to prospective payment. So should we at least know what's happening to those hospitals who are experiencing very significant changes? Thinking about outpatient payment policy especially, when we known that for example a lot of rural hospitals do a lot more business proportionately on the outpatient side than on the inpatient side.

So now we've put them through a pretty significant change in a hold harmless that's going to be pulled back before too long, I think 2003. What impact is that having or will it have on those hospitals? All I'm saying is we're making lots of changes. Congress has made a lot of changes in applying prospective payment to different parts of hospitals, and in my interest of rural hospitals.

What, at least as a baseline, is that doing to the margins -- and I'm most concerned about Medicare margins -- but the Medicare margins for those facilities?

Then it begs the next question, what do you do about that once you know it? And is there the possibility that you've got a decrease in access to health care services for beneficiaries in certain parts of the country?

But at least fundamentally, to be able to see what's happening with Medicare margins for those facilities that are going through very significant changes in payment policy?

DR. ROWE: Could we see the slides again on the distributions?

MR. SMITH: Jack, before we do that, I wanted to raise a question. Jesse, the distribution doesn't tell us anything about beds. It tells us about facilities.

MR. KERNS: It's hospital-weighted so that a very small hospital is going to have as much of an impact as a 500-bed hospital.

MR. SMITH: So that if we wanted to get a more complete

picture of sort of what, given the broad distribution around 3.8, of where that distribution affects capacity, at the moment we couldn't tell that.

MR. KERNS: Not from those slides, no.

MR. SMITH: Wouldn't it be important to know that, to get at some of the questions that Bob continues to raise? If we know that the distribution of facilities is very broad, that really doesn't tell us anything about the distribution of low or high margin beds or capacity.

MR. KERNS: Okay.

MR. SMITH: And if we're going to try to pursue the questions that Carol and Jack and others raised this morning, it would seem to me that would be a critical set of data. Jack, I'm sorry, that's the reason I wanted to interrupt.

I think the distribution material that we have is not really reflective of the distribution of capacity. It's simply reflective of the distribution of facilities.

MR. KERNS: Yes, of the whole market.

DR. REISCHAUER: You could do a distribution of beds here.

MR. SMITH: Right.

DR. ROWE: Could we see the secret slide? Because I'm not a statistician but it seems to me, in looking at this, that there are at least a couple of things that come out. One is that it really doesn't make that much difference whether it's rural, other urban or large urban. Those three lines are pretty much on top of each other.

The second is that there is a reasonable amount of central tendency toward here. This is a relatively kurtotic distribution. Therefore, if we're concerned --

DR. REISCHAUER: A what?

DR. ROWE: Kurtotic.

DR. ROSS: You mean akurtotic, I think.

DR. ROWE: Kurtosis is the central tendency. If you had very little on the outside and a big spike in the middle, that would be more kurtosis, right?

DR. NEWHOUSE: Kurtosis is the fatness of the tails.

DR. ROWE: Then it's akurtotic. We're going to look this up.

DR. REISCHAUER: Are you going to operate on the right leg or the left leg?

DR. ROWE: You know, Bob, you're the only person in America who still thinks I'm a physician. I'm really pleased.

The point I'm trying to make, with a lot of interference here, is that there is a central tendency here. That is, there does not appear to be, at least at this global level of analysis -- and I agree that we should look at other levels. But I also understand that if we torture the data enough they'll admit to anything, so we will find something.

There doesn't seem to be a bulge anywhere with respect on the downside of the places really at risk here. There's a relatively central tendency here. There's not this bulge at the extremes. And it doesn't seem to matter whether it's a large urban area, other urban, or rural. I think that's informative.

MR. KERNS: Could I make the point before we go too much

further? I think we're getting ahead of ourselves. The point of this is to decide whether the total amount of money in the system is adequate. There are distributional issues that are going to come up. It's a long presentation. Jack Ashby is going to talk about a number of distributional things we could do.

When we talk about the plight of certain groups, that's getting ahead of the question of whether the overall amount of money in the system is adequate.

MR. HACKBARTH: Good point, Jesse. And I would like to get to the other points of the presentation. So the issue that Jesse put on the table is is 3.8 percent overall Medicare margin within the zone of adequacy? I heard a little uneasiness from Floyd, simply based on the fact that it's relatively old actual data that we had to roll forward. I think that's an anxiety that all of us share on a whole lot of topics. It's not particular to this one.

Do people generally feel comfortable with the conclusion that 3.8 percent is in the zone of adequacy? If so, I would like to move ahead so we can get into some of the more detailed distributional issues.

MR. SMITH: Glenn, I guess I'm not sure because I'm not sure that it's evenly distributed.

MR. HACKBARTH: The question here has to do, as Jesse put it, with the amount of money in the system. We will address later on whether it's maldistributed or not.

MR. SMITH: But looking at margin by facility and concluding that the modal margin with Jack's even distribution is 3.8 doesn't tell you -- it's not talking about money. It's talking about the distribution of margin by facility.

DR. ROSS: But, David, that's not true. The pictures are different. The 3.8 is a revenue-weighted number. That's dollars in the system. The pictures are facility-weighted.

MR. SMITH: The pictures are facility, okay. That's what I was looking for. Thanks.

MR. MULLER: Just one brief question. There's a 0.5 for both '01 and '02 assumption of cost reduction as a result of length of stay reductions in that estimate; is that correct?

MR. KERNS: There was a small reduction two the market basket increase in costs.

DR. NEWHOUSE: 0.5 for each 1 percent decline in length of stay.

MR. KERNS: And it was about 1 percent decline in length of stay, thankfully. I just don't have the spread sheet here with me, so I'm not absolutely certain of that, but theoretically that's what we did.

That was how we trended forward inpatient. Inpatient is about 70 percent of the costs and 75 percent of the payments. That made a difference of a few tenths of a point. At the end of the day, if we gave them full market basket, the margin might be a 3.7. It's not going to move it very much.

MR. HACKBARTH: I think we're ready to move to the next step here.

* MR. LISK: I'm going to discuss the next section in the chapter, the base rate differential for inpatient payments.

In Medicare's inpatient PPS, the base payment rate for hospitals in large urban areas -- that's metropolitan areas with over 1 million population -- is set 1.6 percent above the payment rate for other hospitals, those in urban, other urban, and rural areas.

Now this current payment differential is the result of policy decisions that were made over a decade ago when the inpatient PPS was first established. Rural hospitals had base payment rates that were 20 percent below those for urban. For urban hospitals, there was no distinction between large urban and other urban. Urban hospitals were all grouped together.

This initial differential was set to reflect differences between urban and rural costs not picked up by doctors including in the payment system at that time. Further analysis, though, showed that that differential was too large.

Starting in 1988, the Congress made separate updates for large urban, other urban, and rural hospitals, effectively creating three separate payment rates, while also substantially reducing differential and base payment rates for rural hospitals between large urban and urban hospitals.

Large urban hospitals received higher updates at the time because the analysis showed that the higher costs of hospitals located in large urban areas were not fully recognized by the prospective payment system at that time.

In 1990, the base rate for rural hospitals was 7 percent higher than that for other urban. The large urban rate was 1.6 percent higher than for other urban hospitals. Congress, at that time though, also decided to eliminate the differential between rural hospitals and other urban hospitals, keeping that 1.6 percent differential between large urban and other hospitals at that point in time. So by 1995, the rural differential was eliminated from the payment rate.

That's the basic history of where we are today. That initial 1.6 percent differential was based on analysis that showed that large urban hospitals costs were higher than the other hospitals.

The capital payment rate has also though -- what I want to inform you about -- there's a 3 percent adjustment in the capital payment rate for large urban hospitals.

If we look at the margin data that Jesse just showed, and this is the data if we take out the DSH payments and IME payments, this is the core base rate margin data, I guess we might call it. Large urban hospital's margins are about 4 percentage points higher than other urban and rural facilities. So this lends some credence to the question about whether the base rates are appropriate in terms of the current differential. So about half this differential can be attributed to the current base rate differential, in terms of the differential in these margins.

Our further analysis that we have also does not support the current differential. Regression analysis we did on 1997 data, and that's because of the data that we had available and ready to be able to do this and that we used before, shows no significant difference in costs between large urban and all other hospitals,

all other hospitals being the group of hospitals we are concerned about in terms of the other rate here. There's no statistical significant difference here. Basically, their costs are the same from the analysis.

If we look at more specifically the rural hospitals, rural hospital costs are likely similar to large urban hospitals in 1999. Our regression analysis for 1997, though, did show that rural hospitals costs were lower than large urban hospitals, about 2 percentage points lower in 1997. But between 1997 and 1999, cost growth for rural hospitals was 2 percentage points more than large urban hospitals, and that's information we actually have.

So given those factors, their cost should be roughly about equal in 1999. Now we can't account for it because we don't have the data to the present time. Cost growth for rural hospitals may, in fact, even have been higher. But this data leads us potentially to the conclusion for you to make that the differential may not be warranted under the current payment system.

MR. MULLER: Do you have the numbers on Medicare margin or just on Medicare inpatient?

MR. LISK: Yes, this is the inpatient margin. The overall margin, the differential is still 4 percentage points.

MR. MULLER: Overall Medicare?

MR. LISK: Yes. That's excluding these numbers. And then there's larger differences if you put back the DSH and the above-cost IME payments.

So that leads us to the draft recommendation we had proposed in the report, that the Congress should gradually eliminate the differential in inpatient rates between hospitals in large urban and other areas.

MR. HACKBARTH: So the line of reasoning here is that historically the differential was put into law because empirically there was a difference in the cost. Over time that difference has disappeared, therefore there should not be a differential in the base rates.

MR. LISK: Correct.

MR. HACKBARTH: Comments?

MR. FEEZOR: Based on any precedents that we have recommended, do we try to suggest a time frame on that? It says gradually. Over what period of time do we interpret gradually to mean?

MR. LISK: I think if you approve this Jack will be getting into that some in his discussion.

MR. HACKBARTH: Just as a matter of process, what I'd like to do is not vote on this particular recommendation now but proceed through the next section.

MS. BURKE: Glenn, can I just add, this is just a language issue. I noticed this earlier and I noticed it here and there may be history here that I don't understand. Is there a particular reason that we have to keep referencing IME payments above costs? I mean, IME payments are IME payments, whether they are or aren't above costs.

MR. LISK: Yes, in terms of how we're talking about the IME

payments that are directly related to the cost relationship between costs and Medicare payments. So we're putting that as though that's still in the base payment.

The IME payments, though, that are above the empirical level, the subsidy is what we're referring to there. So the IME payments above costs, we're just trying to avoid using the word subsidy.

MR. MULLER: But you clarified this morning, it's above the cost of teaching, not above the cost of IME. Because you use it as residual teaching, because you didn't put in the other kind of IME costs. There are costs to being standby, and all that other stuff.

MR. LISK: Those costs though, in how we do it though, are actually still factored in to what we say is the empirical level, though. Those costs are captured by the adjustment.

MR. HACKBARTH: So historically what we did was to examine the relationship between teaching and the costs, all types of costs, and found that those that had more teaching had a higher cost of all type. The empirical adjustment was at one level. The factor written into law was basically twice that empirical level.

And so when Craig uses the term IME above cost, he's talking about the second half of that, the piece above the empirical relationship.

MR. MULLER: But I thought this morning in the discussion you were doing this off -- this may be too technical but if we're going to start using these words -- it was the costs of teaching that you had in your regression; correct? And the other costs historically associated with IME you don't --

MR. LISK: It's residents per bed.

DR. REISCHAUER: It's residents per bed.

MR. HACKBARTH: And the other variable is all costs of care.

MR. LISK: Medicare costs. But the other factor to consider is that when you think about the costs of teaching, if you're talking about the direct costs, those are excluded from this calculation.

MR. MULLER: No, we're talking about the other costs for which the IME adjustment was intended.

MR. LISK: That's being picked up, so everything above the empirical level is more than that.

MR. HACKBARTH: So for example, Ralph, I think you mentioned standby capacity. That would be included as a cost of care.

MR. LISK: If they have higher standby capacity it raises their cost of care, that's going to be reflected in the empirical level; correct.

DR. LOOP: Currently non-allowable costs are picked up in that? That's not true.

MR. HACKBARTH: Not non-allowable costs.

DR. LOOP: Some standby is non-allowable.

MR. HACKBARTH: I'm in over my head on that.

DR. LOOP: I think. And teaching hospitals have more non-allowable costs than non-teaching hospitals. I'm not arguing about non-allowability. I'm arguing whether that's really picked up.

MR. ASHBY: Just wanted to clarify though that there's nothing in the rules of allowability that has to do with standby costs. So if maintaining excess capacity raises your costs, by all means that is captured by the measure.

MR. HACKBARTH: Okay. Are you finished, Craig?

MR. LISK: Yes.

* MR. ASHBY: If you agree with the conclusion that came at the end of Jesse's presentation, that overall payments are adequate, then under our new updating approach we, of course, have no adjustment for payment adequacy. And in the update we account solely for the cost changes in the coming year as measured by CMS' forecast of the hospital market basket.

Now in our traditional updating framework, we considered the cost increasing effects of technological advances and we expected small cost-reducing effects from productivity improvements. But as we've said before, lacking ability to measure either very accurately, we are proposing to assume that the two offset each other. And that comment, of course, can be made across any of our health care sectors.

But specific to the inpatient sector, in each of the last five years we have had a downward adjustment in the update to account for the effects of past unbundling, unbundling being defined here as services being shifted out to various post-acute care settings as the length of stay for inpatient stays decline.

Under our new system, though, we are implicitly accounting for the effects of unbundling as we assess the adequacy of current payments, along with the effects of a host of other factors that may have paid a role in determining the adequacy of today's payments. That could include things like market basket forecast error, productivity changes, upcoding, regulatory changes, and so forth.

In theory, though, we could adjust for unbundling prospectively if we thought that length of stay will fall again in fiscal year 2003. Given that Medicare length of stay did decline nine years in a row through '99 and our preliminary data suggests that it dropped again in both 2000 and 2001, there might be some reason to think that it, in fact, might happen again.

But we note that the length of stay declines have been getting smaller. Our more recent observations are based on rather small samples. And of course we don't, as yet, know anything about 2002. So we think that it would be more prudent to basically wait and see what happens and take the result of any further declines in length of stay into account in assessing payment adequacy the next time around. A prediction here would be rather dicey.

So that leaves us with an update equal to market basket. What we would like to propose is that we consider a set of policy changes that will increase aggregate payments by market basket but would make two simultaneous distributional changes, the first being to take the first step in phasing out the differential and base rates, as Craig was just discussing. And the second being to provide the funds needed to implement the rural recommendations that we made last spring. Those recommendations, of course, very much still stand. We'll take a look at each of

those two changes in the next couple of overheads.

First, the differential. The legislated update is market basket minus 0.55 percent for all hospitals covered by the inpatient PPS. One way that we might structure the first step in eliminating the differential in base rates is by raising the update to market basket even for other urban and rural hospitals, and then leaving the legislated update of market basket minus 0.55 in place for large urban areas. That way we're not taking away from what the large urban group would be expecting under a law that's been in place for the last couple of years.

That really speaks to the point that Sheila brought up at the last meeting, of how difficult and potentially contentious it is to implement these distributional changes. This is, I think, as easy a way to do it as there could be.

Now this change would cut the differential by about a third. We in theory could make a formal recommendation that suggests a three-year phase-out of the differential, but we thought that perhaps it would be wiser to not make such a formal recommendation but rather wait until next year when we will have at least one and perhaps two years of additional data to assess where we are before we then make a recommendation on an appropriate second step.

Then looking back briefly at our rural recommendations, the first two recommendations that we made, the first two proposed payment increases for rural hospitals, would require new money. The first and main one was raising the cap on disproportionate share add-on for most rural hospitals from 5.25 percent to 10 percent. The second was implementing a low volume adjustment.

The third recommendation that you see here, removing select labor categories from the wage index, would be implemented budget neutral. But we included it in our estimates because it would affect the distribution of payments between urban and rural hospitals.

The fourth recommendation, which you don't see listed here, that dealt with the labor share used in the wage index. That cannot be quantified at this point in time because it depends on the outcome of a CMS study that we did recommend. But that one, too, would be done budget neutral and so does not have an impact on the level of payments as we're discussing today.

So in the next overhead, we show our estimates of the impact of these three recommendations. As you see, it ranges from a 0.1 reduction for hospitals in large urban areas to a 1.8 percent increase for rural hospitals.

Certainly this represents a fair amount of coincidence, but if you take the three impacts that you see here, combine them with the differential update that we covered a moment ago, it does on a weighted basis add up to an aggregate increase of payments of market basket even rounded to the nearest tenth percent. That was sort of convenient and it really was coincidental. Obviously, we were not taking any of this into account last spring when we developed these rural recommendations but it does work out that way.

DR. ROWE: What's the market basket?

MR. ASHBY: 2.9 percent is the latest CMS forecast.

Let's move on to the outpatient update then.

MR. HACKBARTH: We may have some discussion of that.

MR. ASHBY: Okay.

DR. ROWE: I just want to get to Allen's point, the question about the timing. This seems perfectly reasonable to me, I'm supportive of all of this. Based on the way this works and the experience and everything else, do we have any sense that it's better if you're phasing something like this out to do it over a longer period of time, a shorter period of time, to front load it, back load it? I mean, how does it work? What's the best way to do this?

DR. REISCHAUER: I was going to say that I thought Jack said that we weren't making a recommendation, in a sense, to phase it out completely or we weren't effectuating that. We were just going to do something that would reduce it by a third.

DR. ROWE: We're taking a third out the first bite. I guess my question is does that seem like a reasonable -- is that the way to do it?

DR. NEWHOUSE: Do you think you'd want to take out more or less?

DR. ROWE: I'm just asking. I'm agnostic. I'm just wondering how it usually works.

DR. REISCHAUER: I think Jack's point is the right one, which is you don't want to surprise large urban hospitals by cutting their payments below what they had been anticipating. And it just sort of happens to work out well this way.

DR. ROWE: I understand.

MR. ASHBY: The other point that I think shouldn't be forgotten here is this all does add up to an aggregate increase in payments of market basket, which is what we say is associated with our finding that payments are adequate. If we put two-thirds of the -- getting two-thirds of the job done here, then we would exceed the aggregate increase.

DR. NEWHOUSE: But I think the general answer to Jack's question about how fast is governed by how big the redistributional impact is and therefore how much you have to protect people.

DR. ROWE: This sounds perfectly reasonable.

DR. LOOP: I'm not quite sure I understand why we're doing this. The rurals are about half of all hospitals. And it's a big mix of hospitals, big, small. Some of them are highly profitable and some are very poor. I'm not sure we know the unintended consequences here of taking money away from the urbans and giving it to the rurals.

MS. BURKE: But I think this scenario --

DR. REISCHAUER: Yes, relative to current law, you aren't taking money away from the large urban. You're giving them what the current law says, but our overall recommendation is that the aggregate update be higher than current law calls for. And we're saying where's that extra going to go? And it's going to go to the rurals and the other urbans.

MR. HACKBARTH: And we do know that on average those two categories have significantly lower margins. Now within those categories there's variation. But that's a problem we're always

plagued with. We've got these broad policy categories and the real world is more complicated.

MR. MULLER: I want to just confirm the answer to that I think maybe Craig gave before. The overall Medicare margin is still a four point spread between the categories of large urban versus other urban and rural once you take the DSH and the IME half out. So in a sense, the differential goes beyond just the DSH and IME policy.

MR. ASHBY: That's right. I think that's the key point. Even putting the DSH and the IME aside and dealing with them as subsidies, when you look only at payments for Medicare services there still is this four percentage point differential. The reason for that would be elusive, given that there are not cost effects.

MR. HACKBARTH: Part of it's related to the fact that there's a base rate differential.

MR. ASHBY: Exactly.

MR. HACKBARTH: We're saying there's no basis any longer for that.

MR. ASHBY: But I mean the justification for it would seem to be elusive, particularly given that there are not cost differences between these groups.

DR. ROWE: But even after you correct for this, there's still an extra 2.5 percent.

MR. ASHBY: Right. But if we're looking for symmetry, I'll offer the possibility of some symmetry coming down the line. And that is that we have a fix to the wage index that's already to be implemented. I think it will probably happen in 2005. And that will likely eliminate the additional differential that you see. There's about two percentage points left.

Most likely, that will disappear when the mix adjustment goes into effect. From what little we know from past analysis, it's about those proportions.

MR. HACKBARTH: Sheila, did you get your point in earlier?

MS. BURKE: Yes.

MR. HACKBARTH: Any other comments? Ready to move on to outpatient then? Just so people don't get lost in the conversation, we do have a series of recommendations that we will come back to and vote on one by one. We wanted to get all the pieces on the table first.

* DR. WORZALA: Good afternoon. Let me start my discussion by giving you an idea of the magnitude of outpatient spending. Spending on the outpatient PPS is projected to be $19 billion in calendar year 2003. So each percentage point change in the base payment would change payments by about $190 million. That's to just give you an order of magnitude.

As requested at the last meeting, here are the margins for hospital outpatient services. As you can see, all hospitals report large negative outpatient margins. However, these margins are difficult to use a measure of financial performance. We suspect that hospital accounting practices resulted in considerable shifting of costs to the outpatient sector because it was, until recently, paid on a cost basis. This is one of the reason we moved to looking at overall Medicare margins rather

than sector-by-sector margins.

In addition, previous payment policy paid only a percentage of costs, making a positive outpatient margin impossible.

For these reasons, we tend to look at outpatient margins for assessing differences across groups rather than to determine absolute financial performance.

That said, we can see that the estimated margins in 2002 show an improvement over 1999 under the assumptions that we have made. This is due primarily to the transitional corridor payments that added new money to the outpatient sector. As you can see, rural hospitals benefit disproportionately from the corridors due to their hold harmless status with a significant improvement in their average margin.

The modeling included only the impact of corridor payments to be received in 2003. So these margins do not include other new sources of money received during 2000 and 2001 and 2002. The reason we did it that way is because these are additional payments that would not affect the base and since our update decision is concerning the base payment rate we did not include additional payments that weren't built into the base.

And here we're talking about the transitional corridor payments and also extra payments received due to implementation of the pass through in a fashion that was not budget neutral. So both of those things would have increased payments in the intervening years but are not modeled in these margins. So I think we can say that these margins in some ways despite their very negative numbers, understate financial performance.

This slide lays out the factors we considered in making the update recommendation that you will consider. Given that we concluded payments to hospitals are adequate as a first step, we make no adjustment to the update for payment adequacy.

Then, consistent with our analytic approach, we use the expected change in input prices as measured by the hospital market basket as our base. We then consider the extent to which other factors are likely to make a significant and measurable difference in costs or payments.

In the outpatient sector the cost of technological advances are accounted for directly, both by the new technology APCs and the pass through payments. The new technology APCs result in new money for each service provided and do not therefore need to be taken into account in the update.

The pass through payments, however, are meant to be budget neutral. Assuming that budget neutrality will be maintained in 2003, these costs should be considered in the update process. However, we have very limited ability to forecast these costs. Therefore, as we've done sort of across sectors, we assume that cost increases due to technology are approximately balanced off by increases in productivity.

However, we think this is a conservative assumption for outpatient services that is likely to go to the benefit of hospitals. This is both because many technological advances will come in through the new technology APCs and also because both CMS and industry sources predict a limited number of pass through technologies to be approved in the coming years. Therefore, the

new technology costs may actually be less than what the productivity improvements would be. However, again, we have very little information to quantify that so we chose not to.

Finally, we considered the effect of implementing a new payment system. The outpatient PPS was put in place in August 2000 and, of course, hospitals incurred some cost to revise billing and information systems, train staff, and adapt to the new payment system. Most of these costs should be absorbed by 2003 however.

On the other hand, the new payment system may provide hospitals with both a tool and an incentive to exert better cost control. Implementation of the inpatient PPS showed that hospitals tend to rein in costs in response to prospective payment and the uncertainty of a new payment system. Again, we can't quantify these things so we make no assumption.

A final issue to consider in regard to implementing a new payment system is the effect of improved coding on payment. The outpatient PPS provides hospitals with an incentive to code correctly. We may therefore find payments increasing in the first years of the system due to an increase in the reported case-mix that is due more to coding improvements than to changes in the services that are provided. So they're not actual case-mix changes, it's just reported case-mix changes.

We would think that this would lead to payments being greater than costs, but again we can't estimate the net impact. So that's something that we'll want to try and measure in the future but at this point in time we make no assumptions on the point.

So after looking at all these factors we concluded that market basket is the appropriate update recommendation for the outpatient PPS and, as it turns out, this conclusion is consistent with current law which gives the Secretary the authority to set the update based on the market basket, barring additional legislation.

I have drafted two recommendation options for your consideration and they are mutually exclusive. The first one simply states our conclusion and directs the Secretary to update outpatient payments based on the market basket. The second one acknowledges that this is consistent with current law and states that the updates and current law is adequate. It's simply a wording difference and one or the other recommendation is sufficient.

MR. HACKBARTH: Do you want to comment, or, Murray, do you want to comment on the relative merits of the two approaches? Why did you see fit to offer an option here? I was expecting one along the lines of the first.

DR. WORZALA: The first is our process and it's our conclusion, but I think previously we've been hesitant to make a recommendation that says do what's in law. Sort of like saying obey the speed limit or something like that. I think it's purely up to you. We certainly did follow a process. We didn't start with current law as the objective and shoot for that target. We followed our process and it came to that conclusion. So I think it's completely up to you.

MR. HACKBARTH: So as I understood what you said, Chantal, in several different instances we made assumptions that were favorable to hospitals in the absence of information, recognizing that under our payment adequacy approach if in the future we find that payments are high relative to costs we can make a recommendation at that point to compensate for any overpayment.

DR. WORZALA: Yes, I think that's the idea.

MR. MULLER: Just a question. But in terms of the payment adequacy framework that we've been adopting the last few months we're saying, even though on the face of it the payments aren't adequate by being minus 17, we're using the inpatient margins being higher as a kind of way of saying therefore it's okay to have inadequate outpatient rates?

MR. HACKBARTH: What I understood was in fact we think those numbers are skewed, they're an artifact of accounting and they're not the real economic profitability or unprofitability of outpatient services.

MR. MULLER: I don't think anybody's arguing there's a 17 percent skewing. Are we arguing that?

MR. HACKBARTH: Actually, I think people are arguing that, just that. Does a staff member want to address that?

DR. REISCHAUER: Presumably, if we're mismeasuring on one side, underestimating, we're overestimating on the other. And so that's why we look at total Medicare margins and we say well, they're 3.8 so on the whole we shouldn't lose sleep tonight.

MR. MULLER: I agree with the way you posed it, but that's different than saying there's a 17 percent skewing on cost reporting.

MR. ASHBY: But, Ralph, the only evidence we have suggests that there is a skewing on cost reporting of about those proportions. Now granted, the study is 10 years old, but I'm not sure that the world has changed dramatically from a cost accounting view. But the finding was at that point that the outpatient costs were -- the actual raise was 15 to 20 percent overstated, which would leave the inpatient rate at about 4 percent or so understated.

DR. ROWE: I think one other consideration here is that -- I'm not sure I completely agree with Bob about the fact that that's why we look at total. And what you lose on the peanuts you make on the potato chips. There's some accounting -- funds are being moved around, costs are being moved around here. So we take care of that by -- I think that's right and reasonable.

But we should at least all be aware that there is a lot of variability across institutions and a lot of individual hospitals have very little outpatient and other hospitals tend to have very large outpatient, particularly in rural areas or in urban areas of underprivileged populations, underserved populations where there aren't as many practitioners in the community.

If you go to Harlem, there are very few doctors working in the community and more care tends to be delivered in outpatient departments of hospitals, et cetera, et cetera. So I think there are these differences.

DR. NEWHOUSE: But if you have a bigger outpatient department you can shift more of your costs there. If you don't

have an outpatient department you won't have cost shifting.

DR. ROSS: Just briefly, to address Ralph's point. I wouldn't phrase it quite that way, that we say it's okay to observe these large differentials, even stipulating to the amount of cost allocation that may have occurred. But we don't yet have a strong case to make on exactly how would we correct it for any underlying differences? We don't want to dramatically underpay for a particular service because of variations across facilities. And we don't want to dramatically overpay for other services. But we don't have the evidence to suggest any precise kind of adjustments.

MR. MULLER: But I think that's the argument -- whether one uses Jack's metaphor or somebody else's -- that the inpatient margins cover a minus 17 and outpatient is one, that people roughly come to some rough sense of justice about.

If on the other hand, in one of the prior pages, we're looking at starting to make differential adjustments in inpatient recommendations because "they're a little higher" then that starts affecting how one things about the balance with outpatient. We're using those higher inpatient margins, in a sense, to cover the lower outpatient programs.

MR. HACKBARTH: The previous discussion was based on overall Medicare margins and differences between large urbans and other urbans and rurals, not just the inpatient. Just to be clear about that.

So it's not a case where we're looking at the high inpatient margin of a large urban and ignoring their loss on outpatient and saying there should be redistribution based on the inpatient margin. We looked at the overall margins and saw that they were significantly higher and that there was no basis empirically for a differential and said we ought to start to eliminate.

Questions or comments? Okay, let's proceed to voting on the recommendations then.

Actually while I'm thinking of it, we do have the two options for the outpatient. Option one, I think, is the one we will vote on, the more straightforward language.

So our first draft recommendation is on the gradual elimination of the differential in inpatient rates.

All opposed?

All in favor?

Abstain?

On this recommendation, all opposed?

All in favor?

Abstain?

And on outpatient, all opposed?

All in favor?

Abstain?

Okay, thank you. I think what we'll do is proceed to discuss paying for new technology in the outpatient PPS. Welcome back, Chantal. We missed you, you were gone so long.